

**EXTERNAL REFERRAL FOR RENFREW COUNTY  
MOBILE GERIATRIC DAY HOSPITAL**

Addressograph

Patient name: _____	CPI: _____	DOB: _____	M / F
		YYYY/MMM/DD	
Patient telephone: _____ HCN: _____			
Address: _____			
Contact person for appointment: _____		Relationship: _____	
Contact number: _____		Family physician: _____	
Referring physician: _____			
Past Medical history: _____			
Drug Profile list attached <input type="checkbox"/> or Medication list: _____			
Pharmacy: _____ Allergies: _____			
Current community services: _____			

Referral site:     Pembroke             Renfrew             Arnprior  
 Urgent referral:  Yes                       No

**Reason for Referral:**

- |                                       |  |  |
|---------------------------------------|--|--|
| <input type="checkbox"/> Cognition    | <input type="checkbox"/> Mobility        | <input type="checkbox"/> Falls           |
| <input type="checkbox"/> Driving      | <input type="checkbox"/> Mood            | <input type="checkbox"/> Incontinence    |
| <input type="checkbox"/> Polypharmacy | <input type="checkbox"/> Future planning | <input type="checkbox"/> Pain management |
| <input type="checkbox"/> Other: _____ |  |  |

**Exclusion Criteria:**

- acute unstable medical condition, eg: recent MI or CVA,
- an infectious/contagious condition
- unable to follow 2 step commands
- can not tolerate 30 minutes of low level activity (sitting exercise)
- previous diagnosis of moderate to severe dementia preventing the patient from being able to participate in the Mobile Geriatric Day Hospital Program.

**\*Urgency criteria**

Non-urgent – at risk of functional decline and have 2 or more issues if addressed will enable them to remain at home longer.

Urgent – newly identified or progressive concerns about cognition/functional status/behaviours (often delirium, driving, medication, falls)

Thank you for your referral. Please attach any relevant discharge summaries and /or test results.  
Please fax to 613-732-6356

**GERIATRIC EMERGENCY MANAGEMENT REFERRAL FOR  
 RENFREW COUNTY MOBILE GERIATRIC DAY HOSPITAL**

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Issue	Active problem	Comments
Cognition	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does patient drive?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mood	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Behaviour ETOH Smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	
Mobility  Falls	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No	Gait aids? <input type="checkbox"/> Cane <input type="checkbox"/> 2WW <input type="checkbox"/> 4WW
Function a) ADL  b) IADL	<input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> Yes <input type="checkbox"/> No	
Nutrition	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Medication concerns?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Continence (Bladder/bowel)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Skin integrity	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Caregiver Issues	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_  
 YYY/YYY/YY

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 YYY/YYY/YY